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FEDERAL SECURITY AGENCY
National Office of Vital Statistics

MISSOURI DIVISION OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 34239

FILED OCT 23 1948 318 1005 1005

Registration District No. ______ Primary Registration District No. ______ Registrar's No. 8812

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:

(a) County
(b) City or town ST. LOUIS MO
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 2703 ARKANSAS
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution ______ In this community ______ (Specify whether years, months or days)

2. USUAL RESIDENCE OF DECEASED:

(a) State MISSOURI (b) County
(c) City or town ST. LOUIS
(If outside city or town limits, write "RURAL")
(d) Street No. 2703 ARKANSAS
(If rural, give location)
(e) Citizen of foreign country? ______ (Yes or No)
If yes, name country ______

3. (a) PRINT FULL NAME OSCAR C. HENKE

3. (b) If veteran, name war ______

3. (c) Social Security No. ______

4. Sex MALE

5. Color or race WHITE

6. (a) Single, widowed, married, divorced Wid

6. (b) Name of husband or wife ______

6. (c) Age of husband or wife if alive ______ years

7. Birth date of deceased SEPT (Month) 30 (Day) 1865 (Year)

8. AGE: Years 83 Months — Days 11 If less than one day ______ hr. ______ min.

9. Birthplace ST. LOUIS (City, town, or county) MO (State or foreign country)

10. Usual occupation CHINA & GLASS MERCHANT

11. Industry or business ______

FATHER
12. Name EDWARD C. HENKE
13. Birthplace (City, town, or county) GERMANY (State or foreign country)

MOTHER
14. Maiden name MINNA WUNDERLICH
15. Birthplace (City, town, or county) GERMANY (State or foreign country)

16. (a) Informant ADELINE HENKE
(b) Address 2703 ARKANSAS

17. (a) BURIAL (Burial, cremation, or removal) (b) Date thereof OCT. 13 1948 (Month) (Day) (Year)
(c) Place: burial or cremation ST. MATTHEWS, CEM.

18. (a) Signature of funeral director Thos. Kutis & Son
(b) Address 2906 GRAVOIS ST LOUIS, MO

19. (a) OCT 11 1948 (Date received local registrar) (b) [signature] (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month OCT. day 11 year 1948 hour 8 minute A. M.

21. I hereby certify that I attended the deceased from 10-9-48, 19__, to 10-11-48, 19__; that I last saw him alive on 10-10-48, 19__; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death: acute myocarditis	2 days
Due to: chr myocarditis since 1945 from Dr. ? Schwab (history)	1945
Due to:	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify) ______
(b) Date of occurrence ______
(c) Where did injury occur? ______ (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? ______ (Specify type of place)
While at work? ______ (e) Means of injury ______

23. Signature John Blaine Bishop (M. D. or other)
Address 1715 So 39th Date signed 10-11-48

(Licensed Embalmer's Statement on Reverse Side) St Louis (C) mo Flynn

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Leo J. Budde

Licensed Embalmer No. 3989

P. O. Address St. Louis, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply wi the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

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WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

THE STATE BOARD OF HEALTH OF MISSOURI
STANDARD CERTIFICATE OF DEATH

State File No. 1107

Registration District No. 318 Primary Registration District No. 1003 Registrar's No. 8812

1. PLACE OF DEATH:

(a) County

(b) City or town St Louis
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:

(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution (Specify whether years, months or days)
In this community

2. USUAL RESIDENCE OF DECEASED:

(a) State (b) County

(c) City or town
(If outside city or town limits, write "RURAL")

(d) Street No.
(If rural, give location)

(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Oscar C. Henke

3. (b) If veteran, name war

3. (c) Social Security No.

4. Sex M

5. Color or race W

6. (a) Single, widowed, married, divorced Widower

6. (b) Name of husband or wife —

6. (c) Age of husband or wife if living years

7. Birth date of deceased Sept 30 1865
(Month) (Day) (Year)

8. AGE: Years 83 Months Days If less than one day hr. min.

9. Birthplace (City, town, or county) MO (State or foreign country)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace (City, town, or county) (State or foreign country)

14. Maiden name

15. Birthplace (City, town, or county) (State or foreign country)

16. (a) Informant

(b) Address

17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)

(c) Place: burial or cremation

18. (a) Signature of funeral director

(b) Address

19. (a) (Date received local registrar) (b) J. B. Lasater (Signature) OCT 29 1945

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Day year 1945 hour minute M.

21. I hereby certify that I attended the deceased from 19 to 19, ; that I last saw h alive on 19, ; and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	
Major findings: Of operations	
Of autopsy	

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify)

(b) Date of occurrence

(c) Where did injury occur? (City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

S-34239